

Time to legalise assisted dying?

RCGP is not neutral: it opposes a change in legislation

EDITOR—Delamothe states that the Royal College of General Practitioners (RCGP) has a neutral stance on the issue of assisted dying.¹ This is no longer correct.

At a meeting of the college council in June 2005 it was decided, by a clear majority, that the college could no longer maintain a neutral stance on the subject of assisted dying. To determine a definitive position on whether to oppose any future legislative change the college sought further views from its faculties and membership. After careful consideration of the views received and further debate at a meeting of its council on 16 September 2005 the college issued the following position statement:

“The RCGP believes that with current improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed.”

I also issued the following statement:

“This is an important and clear decision by the council of the RCGP. The RCGP is the largest medical royal college with over 23 000 members. Great care and attention has been taken over this debate, which has now been considered by council twice. The college does not support a change in legislation.”²

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Competing interests: None declared.

1 Delamothe T. A time to die? [Editor's choice]. *BMJ* 2005;331. (24 September.)

2 RCGP statement on assisted dying. 21 September 2005. www.rcgp.org.uk/press/2005/0067.asp (accessed 28 Sep 2005).

Response from the Association for Palliative Medicine

EDITOR—We challenge Sommerville's view that it is acceptable for the BMA to adopt a neutral stance on assisted dying.¹ This reversal in BMA policy will considerably strengthen the position of those wishing to change the law.

We believe that the proposed legislation allowing assisted suicide will fundamentally affect the practice of all doctors and it is therefore imperative that the BMA should reflect the genuine view of its membership. Both the Association for Palliative Medicine and Royal College of General Practitioners made strenuous efforts to ascertain their members' views. This is in sharp contrast to the BMA, where a tiny majority (11 delegates) effected a major shift in policy without reasonable attempts to consult the membership.

The association's survey found that over 90% of practising palliative medicine physicians opposed a change in the law.² The royal college also supported a position of opposition.³ As the ethics committee of the Association for Palliative Medicine, we can be confident that we continue to represent the views of our

members in opposing the proposed legislation on assisted dying.

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Competing interests: None declared.

1 Sommerville A. Changes in BMA policy on assisted dying. *BMJ* 2005;331:686-8. (24 September.)

2 Memorandum by the Association for Palliative Medicine. Select Committee on the Assisted Dying for the Terminally Ill Bill. www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/4102110.htm (accessed 29 Sep 2005).

3 RCGP statement on assisted dying. 21 September 2005. www.rcgp.org.uk/press/2005/0067.asp (accessed 28 Sep 2005).

BMA should take an active role, whatever that may be

EDITOR—Delamothe said: “Any mention of euthanasia in the *BMJ* seems to precipitate a barrage of criticism from opponents of a change in the law that drowns out the messages of support. Do the opponents have more, or better, arguments than the supporters of a change in the law? Are they more numerous, better organised, or just noisier?”¹ This is indeed a worry, and many discussions about euthanasia which I have attended often entail proponents who are

pro-euthanasia being labelled Nazis, which is neither helpful nor true.

Opponents are not necessarily more organised or armed with better arguments, and I speak as an opponent to a change in the law. In my experience, opponents often simply use the Nazi card, evoking a purely emotive image with little basis on reasoning.

However, in such discussions, it does not help that the BMA decided to drop its opposition to the legalisation of assisted dying. Dropping opposition is not necessarily a signal of agreement with the advocates of the other side. Why doesn't the BMA take an active role, voicing its opinion—whatever that may be?

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1 Delamothe T. A time to die? [Editor's choice]. *BMJ* 2005;331. (24 September.)

What autonomy really means

EDITOR—Branthwaite makes it all sound simple.¹ For the assisted dying lobby, autonomy is the ruling principle in medical ethics. It trumps all other principles. But there is a deep irony here: death abolishes autonomy. Dead men cannot choose. So if you really respect autonomy, you have to be very careful about giving autonomy its head.

Of course if people are simply asked: “Would you like to be in control when you die?” most would say that they would. But being truly in control means being in possession of sufficient information to make an informed choice, as well as being in a state of mind properly to consider that information.

Sufficient information, in the case of a truly autonomous assisted dying, must mean all relevant information: there will be no chance to review things later. Few people at the stage of considering assisted dying for themselves will have either all the relevant information or be able to weigh it. The relevant information will include medically sophisticated details of prognosis and all the

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palliative options, including terminal sedation to unconsciousness.²

It will be impossible for even well-meaning clinicians giving such counselling to exclude entirely their own view of the matter and give impeccably objective advice. Vulnerable patients will quite easily be talked into death. Many patients will be (treatably) depressed, which will interfere with their ability to weigh the information given to them. Many will opt for assisted dying not because they have autonomously decided on the evidence that death is the best option, but because they do not want to be a burden to their carers or their family.

Autonomy would mourn such deaths, and the lawyers, applying the conventional principles of the law of consent, will be out to avenge them.

It is wrong to let autonomy reign alone, but if it does, it forbids the conclusion argued for in its name.

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Competing interests: None declared.

- 1 Branthwaite MA. Time for change. *BMJ* 2005;331:681-3. (24 September.)
- 2 Foster C. Misrepresentations about palliative options and prognosis in motor neurone disease: some legal considerations. *Journal of Evaluation in Clinical Practice* 11(1):21-5.

Do we make decisions by our feelings or the truth?

EDITOR—The *BMJ* seems to accept the policy of neutrality towards physician assisted suicide, despite reported undemocratic voting at the annual representative meeting.¹

Tännsjö argues for euthanasia, not just physician assisted suicide.² He follows the modern trend to make decisions by what “feels comfortable” rather than by what is objectively right. He then looks for a suitable framework to justify his opinion. This seems to be in complete contradiction to the evidence based requirement of the rest of medicine.

The public fears over-burdensome treatment. We have a right to express our wishes, but we do not have automatic access to all we want. Even if we plan physician assisted suicide, we should be prepared for unexpected events—for example, an allergy reaction or vomiting up “the blue pill.”

The use of autonomy as a basis for ethics is flawed: it is mistakenly identified with freedom. One person's rights impact on others' duties—that is, doctors are being asked to hand a patient the means to kill himself or herself. Suicide has been de-criminalised, but it harms human nature. Physician assisted suicide could have far reaching implications on the family and society in general. Assistance would be contrary to the practice of doctors, who spend many surgery hours persuading people to step down from the window ledge. Physician assisted suicide proposes that we give in to their hopelessness and help them to jump comfortably.

Workload might be reduced but human richness would also be lost. Suffering can increase the insight and appreciation of the

beauty of life. Some of the best artists and poets have been depressed, and we would never have had the Goons without Spike.

Let's leave the physician out of physician assisted suicide and say euthanologist. This would not endanger or destroy the doctor-patient relationship, and the funding would not come from an already tight healthcare budget.

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Competing interests: None declared.

- 1 Irwin M. Many left before the vote. Opinion. *BMA News* 2005 July 23:6.
- 2 Tännsjö T. Moral dimensions. *BMJ* 2005;331:689-91. (24 September.)

No, thank you

EDITOR—Many moons ago I read George Orwell's *1984* and *Animal Farm* as imaginative and perhaps intimidating works of fiction. It seems that others are basing their recommendations on these works.¹

Should we place all family life (and death) in the hands of bureaucrats? We have already increasingly shifted responsibility towards the government, which frequently uses cost as the only criterion on which to base a decision. Go the whole hog. Give each child a credit value. Deduct costs of education, dental care, medical treatment; add to its value any tax and national insurance contributions, but when the cash balance reaches zero life becomes forfeit.

When I look at decisions made on behalf of lesser mortals by those deemed to be wise I shudder. No, thank you: leave me to muddle along.

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- 1 Delamothe T. A time to die? [Editor's choice]. *BMJ* 2005;331. (24 September.)

Recruiting more vulnerable doctors may be the answer

EDITOR—George et al are right to draw attention to the connection between euthanasia and the rights of disabled people.¹

For a long time, medicine has unwittingly been perpetuating the notion that only those who seem to be beautiful, intelligent, and useful are of value to the human race. Initiatives to encourage more disabled students to enter medical school and become doctors may be the answer. Doctors who currently doubt the value of the life of a patient may then be better placed to understand true human value.

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Competing interests: AT has written several reports on the admission of disabled students to medical, dental, and veterinary schools.

- 1 George RJD, Finlay IG, Jeffrey D. Legalised euthanasia will violate the rights of vulnerable patients. *BMJ* 2005;331:684-5. (24 September.)

Use of Baxter products in figure for physician assisted suicide was inappropriate

EDITOR—I regret the use of a figure that includes one of Baxter Healthcare's products in kits available to Belgian general practitioners who want to help patients die at home, as shown in the article by Branthwaite on changing the law on euthanasia and physician assisted suicide.¹

For more than 70 years Baxter has been dedicated to saving people's lives. We offer products and services that help to treat people with some of the most challenging medical conditions, including cancer, haemophilia, immune deficiencies, infectious diseases, kidney disease, and trauma. Using our products to end lives contradicts everything we are in business to do: provide lifesaving treatments.

We market products for important and legitimate medical uses. These products have been used safely and effectively for decades. We do not control how our products are applied, and they are widely used and available through many sources, not just through us. Although we cannot control how our products are administered, we intend that they are used safely and appropriately.

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Competing interests: MB is medical director at Baxter.

- 1 Branthwaite MA. Time for change. *BMJ* 2005;331:681-3. (24 September.)

Doctors cannot simultaneously be patient centred and reject assisted suicide

EDITOR—You can't aspire to be patient centred and simultaneously reject assisted suicide.¹ That's the discomfort that afflicts the Royal College of General Practitioners and other doctors who reject assisted suicide. They cling to a world where “doctor knows best,” a world that is as dead as “politicians know best and so be respectful and follow what we do.”

Of course, assisted suicide is anathema to many. But to an equal number—and probably more—it has the potential to allow a graceful and dignified exit from life.

I (HS) am 75, fit, and enjoying life, although I lost my husband of more than 50 years last year. I'm not lonely, and being on my own allows me to do things that weren't possible when my husband was alive—like listening to Beethoven string quartets, which he found tuneless and mournful. But my life is diminished, and the work of my life is done. I have no fear of death, but I dislike intensely the idea of being demented and institutionalised. I'm moderately confident that doctors will be able to handle the pain that may come towards the end of life (although I've encountered many examples where they failed), but they cannot counter the loss of dignity, personhood, and control that comes with dementia.

If I feel dementia approaching, I could of course kill myself. There's nothing illegal about that, but I would be reluctant to involve my family and friends—for fear that they might be implicated in doing something illegal. Yet I don't like the idea of sneaking off and doing it alone, not least because I might mess it up and end up in exactly the state I'd like to avoid. I'd much rather that my doctor help me—isn't that what doctors are for?

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Competing interests: HS and RS are both going to die and so are naturally concerned about how death will happen.

1 Delamothe T. A time to die? [Editor's choice]. *BMJ* 2005;331. (24 September.)



Summary of responses

Two weeks ago Delamothe asked in his Editor's choice: "Are you for, against, or—like the BMA ...—neutral?" The subject was assisted dying, and the flood of responses sparked by Editor's choice and the five Education and debate articles made it very clear that neutrality was not a concept that the many respondents found acceptable, conceivable, or even possible.¹⁻⁶ A notable complaint was the lack of balance in the views presented, which had been aggravated by some infelicitous editing of the week's homepage. Responders were mainly doctors from the United Kingdom, although several barristers, philosophers, and a nurse also put their views forward.

Sommerville explained the changes in the BMA's policy on assisted dying towards neutrality, and her 19 responses variously pointed out that there is no such thing as a neutral position and urged the association to change to a policy of opposition.⁴ Most were adamant that they had not, in the words of one respondent, become doctors to kill people. Others reminded us that the BMA decision had been made by very few for the many. On the whole, the emphatic view was that legalising assisted suicide would do more harm than good to individuals and society.

George et al posited that legalised euthanasia would violate the rights of vulnerable patients and lead to killing without consent, the ultimate violation of autonomy. The 16 respondents agreed.³ Patients who want to kill themselves have no right to expect others to do it for them, and death is not a treatment.

Branthwaite argued that terminally ill patients seeking assistance to die should be given the same respect for self determination as those who can end their lives. About a dozen respondents expressed concern for vulnerable patients (for example, people with disabilities); clarified that assistance to die would not amount to suicide but was a euphemism; and pointed out that doctors withholding treatment and patients refusing to have it was totally different to doctors administering a lethal injection and patients

demanding it.² Legalising assisted suicide would destroy trust in doctors.

This was also the main tenor of the responses to the 100 or so responses to Delamothe's Editor's choice, which, however, also had a few lone voices speaking in favour of legalising assisted suicide (but still only in single figures).¹ The need for good palliative care was emphasised by many respondents, as was the philosophical position that we do not have the right to end our lives—and certainly no right to expect others to help us do so.

The overwhelming response from our readers remains that physician assisted suicide is not what they became doctors to do.

The *BMJ's* previous editor, Richard Smith, asks for people to stop thinking of death as taboo and give thought to advance directives: "It's a very good idea to think about our death well before it happens—not least because it could happen to any of us anytime."

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Competing interests: None declared.

1 Electronic responses. A time to die. <http://bmj.bmjournals.com/cgi/eletters/331/7518/0-g> (accessed 30 Sep 2005).

2 Electronic responses. Time for change. <http://bmj.bmjournals.com/cgi/eletters/331/7518/681> (accessed 30 Sep 2005).

3 Electronic responses. Legalised euthanasia will violate the rights of vulnerable patients. <http://bmj.bmjournals.com/cgi/eletters/331/7518/684> (accessed 30 Sep 2005).

4 Electronic responses. Changes in BMA policy on assisted dying. <http://bmj.bmjournals.com/cgi/eletters/331/7518/686> (accessed 30 Sep 2005).

5 Electronic responses. Moral dimensions. <http://bmj.bmjournals.com/cgi/eletters/331/7518/689> (accessed 30 Sep 2005).

6 Electronic responses. Dutch experience of monitoring euthanasia. <http://bmj.bmjournals.com/cgi/eletters/331/7518/691> (accessed 30 Sep 2005).

LIFT study to continue as planned

EDITOR—The long term intervention on fractures with tibolone (LIFT) study is a randomised trial to determine the effect of treatment with tibolone on risk of vertebral fracture in older osteoporotic postmenopausal women. The average age of the 4538 participants is 68 (SD 5.2) years. They have a bone mineral density t score at the total hip or spine ≤ -2.5 without a fracture or a t score ≤ -2.0 with a fracture. Participants were assigned to 1.25 mg tibolone or placebo and followed up periodically for clinical outcomes and safety. The trial started in 2001, and the primary outcome analysis is scheduled for June 2006.

A data safety monitoring board periodically reviews the unblinded results. A steering committee, whose voting members are investigators independent of the sponsor, Organon, oversees scientific issues. The monitoring board notified the sponsor and steering committee of an increased risk of stroke during an average of 2.4 years of the trial. Twenty three cases of stroke occurred during 5399 woman years of observation during and after treatment (4.26/1000 woman years) with tibolone and nine during


5493 woman years with placebo (1.64/1000 woman years), a difference of 2.62 cases per 1000 woman years of treatment (95% confidence interval 0.59 to 4.65 per 1000 woman years) and a relative risk of 2.59 ($P=0.01$).

The monitoring board urged the trial to continue as planned in view of a full assessment of current benefits and risks, and because important additional scientific data will be generated. The steering committee concurred with these recommendations. Organon has notified participants and investigators. The LIFT trial is continuing with ongoing monitoring by the data safety monitoring board.

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 Details of the members of the LIFT Steering Committee are on bmj.com

Capacity building in collaborative research is essential

EDITOR—Scientists from developing countries are seriously under-represented in various areas of health research.^{1,2} Capacity building in developing countries is essential to improve health research and reduce health inequity.^{3,4} We report a retrospective analysis of original articles that appeared in the *BMJ*, the *New England Journal of Medicine*, and the *Journal of Epidemiology and Community Health* between October 2003 and September 2004.

We noted information on the number of contributing authors and their country affiliation by income.⁵ We also classified the scientific contributions of authors from middle income and low income countries as being "major and intellectual" (contributing to two out of three: study conception or design, analysis, and intellectual contribution to manuscript drafting) or "operational" (contributing to data collection, routine supervision, etc).

The three journals reviewed 659 articles. The median number of authors per article was five (range 1-29). Single author publications were rare (3.2%). The numbers of articles that included authors from all three categories were 646 (97.8%), 49 (7.4%), and 11 (1.6%), respectively. Forty seven (7.1%) of the articles were products of collaborations between authors from different country groups: 38 between high income countries and middle income countries, seven between high income countries and low income countries, and one between all three. The nature of collaboration was such that the authors from middle income and low

Extent and nature of research collaborations between countries classified by income in the three journals studied

Characteristic	No (% of total)
Total articles	659 (100)
No of articles based in a middle income or low income country but with no local representation*	2 (0.3)
No of research collaborations involving authors from:	
Middle income countries	38 (5.8)
Low income countries	9 (1.3)
Total	47 (7.1)
Role of the 47 authors from middle income or low income countries in research collaborations:	
Predominantly intellectual	12/47 (25)
Predominantly operational	35/47 (75)

income countries had mostly "operational" roles in research (table). In two instances (0.3%), research papers had no representation from the low income countries where the research was conducted.

Equity in health research is important to reduce health inequity. There is no better time than now for us to translate into practice the rhetoric of strengthening research capacity in developing countries.

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Competing interests: None declared.

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Bridging the equity gap in maternal and child health

Health systems research is needed to improve implementation

EDITOR—As an adviser to district health managers on priority setting, I am concerned with the constant return to a call for more research on cost effectiveness as the solution to improved implementation of health services in developing countries.¹ Cost effectiveness information is useful, but it is far from adequate when a district health manager needs to make a decision and include stakeholders for priority setting.

To know if one intervention against malaria is more cost effective than another against HIV/AIDS, is for all practical purposes useless information to a district policy maker. This type of information is only really useful when they have to choose between two interventions tackling the same challenge. The district health manager is up against a range of stakeholders, all with differing values and criteria for setting priorities. Cost effectiveness is only one of

them.² Unless they have tools to also measure and include other values such as equity, trust, and human rights, we cannot expect that the priorities reached will be trusted or implemented by the various stakeholders.

More research is therefore needed on how to ensure trust and equity, even at the possible expense of cost effectiveness. We are conducting this type of research using the accountability for reasonableness framework in Tanzania, Zambia, and Kenya.^{3,4} The same framework is also being assessed in terms of its usefulness to district health managers in Tanzania, in which we are aiming at providing capacity building for fair priority setting.⁵

For a district health manager more of the same is not the answer. They need research and tools enabling them to implement efficient interventions through a priority setting process that is fair. The values and criteria behind the priorities set need to be explicit and with a wide ownership among the stakeholders affected.

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Competing interests: None declared.

- Bhutta ZA. Bridging the equity gap in maternal and child health. *BMJ* 2005;331:585-6. (17 September.)
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Lay health workers may help bridge equity gap in maternal and child health

EDITOR—As Bhutta has noted,¹ ensuring that human resources in health services are appropriate remains a problem in many low and middle income countries. The renewed interest in community or lay health worker programmes is partly a result of this, and also of the growing understanding of the important roles that lay people can have in supporting treatment and care for people with HIV/AIDS, tuberculosis, and many other chronic illnesses.

To my knowledge, a recently completed Cochrane systematic review of the effects of

lay health workers in primary and community health care is the first attempt to summarise the global evidence from randomised controlled trials on the effectiveness of such interventions.² Based on 43 trials, it shows that deployment of such workers shows promising benefits—for example, in promoting immunisation uptake and improving outcomes for acute respiratory infections and malaria—when compared with usual care. It also highlights a wide range of other health issues for which evidence of the effectiveness of lay health worker programmes is insufficient to justify recommendations for policy and practice.

Lay health workers could potentially contribute to reducing inequities in global maternal and child health, but further rigorous studies of their impacts, sustainability, and transferability, as well as the factors affecting the scaling up of such programmes, are needed urgently. We hope that this review will help to focus this research where it is most needed.

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Sarcomas and specialism

EDITOR—Mannan and Briggs seek to raise awareness of the diagnosis of sarcoma in patients with new soft tissue masses, instead raising some important general questions about the changing NHS.¹

The editorial seems to be aimed almost entirely at general practitioners, although the average family doctor will see perhaps only one case every 24 years. Most new lumps seen by general practitioners will end up being referred to a local consultant surgeon, who will need to use his or her own clinical acumen to decide on management or onward referral. Unfortunately the article does not provide any information that will help such a hospital specialist. The article's advice that any lesion causing concern, whether superficial or deep, should be referred to a specialist centre on an urgent sarcoma two week wait form rather implies that the ideal management is that all patients with doubtful lumps should be sent direct to specialist centres.

As a hospital consultant, I would be only too happy if my nearest sarcoma centre, some 75 km away, were to take all large lipomas off my hands. But the longer term consequences of turning both general practitioners and local specialists into triage agents for large specialist centres will be profound and harmful for national health care. If there is no more specific advice about management, then there should be

discussion about the management after tertiary referral. Without such discussion these patients simply disappear into the black hole of a specialist centre and the rest of us are none the wiser.

More and more categories of patients are being deemed in need of this supra-specialist care. If that process continues too far then the NHS will may one day consist entirely of such centres, and the perfectly good skills of perfectly good clinicians working outwith them will simply evaporate.

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Competing interests: None declared.

1 Mannan K, Briggs TW. Soft tissue tumours of the extremities. *BMJ* 2005;331:590. (17 September.)

Working time directive shift patterns may improve care

EDITOR—The reports of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) focus on reducing surgical morbidity and mortality through minimising out of hours operating, limiting “after midnight” operating to absolute emergencies and increasing senior input into cases.¹ Acceptable waiting times for such surgery also exist²—that is, emergencies (American Society of Anesthesiologists (ASA) score of 4-5) < 1 h, urgent (ASA score 1-3) < 24 h. Rota changes as a result of the European working time directive potentially influence efficiency in theatre.

Our institution provides a 24 hour emergency operating theatre for urgent or emergency surgery. Anaesthetic cover during daytimes, Monday to Friday, is by consultants. Out of hours and weekend cover is from a two tier trainee rota (compliant with the directive) with on-call support from consultants. Before March 2004 the trainees worked a non-resident 24 hour on-call rota.

To assess emergency theatre use we performed a prospective audit, comparing two three month periods before and after work-

ing under the new directive: December 2003-February 2004 and April-June 2004. During the second audit cycle, trainees' roles were extended to overnight preoperative assessment of urgent cases. Data included ASA status (1-3 or 4-5); start times “daytime” (08.30-17.59), “evening” (18.00-23.59), and “after midnight” (00.00-08.29); median waiting times before surgery; median time for “first case of the day” (08.30 being “start of the day”); and seniority of care (anaesthetic and surgical).

We used the χ^2 test and Fisher's exact test to analyse contingency tables comparing start times and seniority of medical staff (where $n < 5$) with two tailed probability. We used the Mann-Whitney U test to compare median waiting times for surgery (we regarded $P < 0.05$ as significant).

Numbers were comparable ($n = 195$ v $n = 191$). Evening operating (18.00-23.59) and median waiting times for patients with an ASA score 1-3 were significantly reduced ($P = 0.033$ and $P < 0.0001$, respectively). Anaesthetic care directly from a consultant was significantly increased ($P < 0.0001$). Median start changed from 11.00 to 09.30, consultants previously performing preoperative assessment in this period (table).

Working and overnight preoperative assessment under the European working time directive improved use of the emergency theatre and care for patients. No reduction occurred in cases operated on after midnight. Case mix (immediate life, limb, organ threatening conditions) indicates that such surgery was appropriately timed.

The directive is aimed at minimising adverse effects of fatigue,³ but potential for swapping one unsatisfactory situation for another exists: reduced continuity of care and reductions in case mix limiting experience.⁴ This audit adds to debates surrounding the directive. It was associated with improved care as judged by recognised guidelines and in addition it potentially provides “through the night” training opportunities in communication and leadership. The non-resident nature of previous rotas prevented any regular overnight periopera-

tive care except in “true” emergencies. Now trainee anaesthetists can take the lead in initiating preoperative management.

Limitations to our audit include observer bias and lack of blinding creating positive reinforcement of the importance of theatre use. Alternatively this could be cited as improving care through increased staff awareness and communication between specialties. Disturbances to patients through being woken are balanced by improved preoperative assessment, reduced waits (potentially reduced starvation times), and subsequent consultant care.

Patients being assessed preoperatively by one anaesthetist and cared for by another also deserve a mention. National guidelines regarding standardisation and documentation of handovers of clinical responsibility would be welcomed.⁵ The process may have to be modified pending guidance. Specific analysis of delays would also enhance future work—for example, absolute staff availability, adequacy or availability of investigations, portering, etc.

Management of patients improved after work patterns and overnight preoperative assessment were introduced according to the European working time directive. This was associated with the advantage of two tiers of anaesthetic trainees. To introduce (and enhance) such improvements, assessment of current practices in individual centres is necessary—for example, actual emergency workload, number of on-call tiers, presence or absence of emergency departments, timing of cases, and “overnight” commitments of anaesthetic teams (such as consideration of anaesthesia and critical care in managing non-surgical patients), impact of restructuring of postgraduate medical training, and perceptions of flexible working held by healthcare's non-clinical stakeholders.

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Competing interests: JFC is clinical lead for emergency theatre at the Freeman Hospital.

Summary of results

Variable	December 2003-February 2004 (n=195)	April-June 2004 (n=191)	P value
No of patients with ASA score (%):			
1-3	179 (92)	173 (91)	0.72
4-5	16 (8)	18 (9)	
No of patients at start time (%):			
08.30-17.59	132 (68)	147 (77)	0.053
18.00-23.59	49 (25)	31 (16)	0.033
00.00-08.29	14 (7)	13 (7)	1.0
Median wait in hours (interquartile range):			
ASA 1-3	16.3 (4.0-21.5)	7.25 (3.0-19.0)	<0.0001*
ASA 4-5	<1	<2.5	
Consultant present:			
Anaesthetist	53	104	<0.0001
Surgeon	66	83	0.06
Time of first case of the day (range)	11.00 (09.30-23.00)	09.30 (08.30-14.00)	

All operating after midnight entailed (as a minimum) anaesthetic and surgical specialist registrars from years 4 and 5 of training.

*Mann-Whitney U test.

1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD). *Who operates when?* London: NCEPOD, 2003.

2 Royal College of Anaesthetists. *Raising the standard. A compendium of audit recipes.* London: RCA, 2000.

3 Douglas NJ. Sleep, performance and the European working time directive. *Clin Med* 2005;5:95-6.

4 Chesser S, Bowman K, Phillips H. The European working time directive and training of surgeons. *BMJ* 2002;325(suppl):69.

5 Horn J, Bell MDD, Moss E. Handover of responsibility for the anaesthetised patient—opinion and practice. *Anaesthesia* 2004;59:658-63.

Which career first?

Women remain caught in dilemma

EDITOR—Free choices about having children cannot be made with partial knowledge, economic disadvantage for mothers, and unsupportive workplaces.¹ I believe that Bewley et al are absolutely right in this and in their following argument for better support for mothers citing the cost to the state and employers of women delaying pregnancy—which got a little lost in the media furore about women “defying nature.”

However, meanwhile women remain caught in the dilemma: to delay pregnancy and incur the risks, or to have children and lose out on career opportunities, earnings, and pension. Although it remains important to strive for better support for mothers in the future, they have to choose in a current climate that is as unsupportive as the authors described. This means that advice concentrating on the risks of pregnancy after 35 could increase this dilemma and instil a sense of guilt and selfishness, while not addressing the circumstances in which this choice is being made.

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Competing interests: None declared.

¹ Bewley S, Davies M, Braude P. Which career first? *BMJ* 2005;331:588-9. (17 September.)

Skewed argument should be put to bed

EDITOR—I write on behalf of all of us childless women who are defying nature and risking heartbreak, as Bewley et al say in their editorial.¹ The fact is many of us have had no choice but to settle for a career instead of motherhood (or both). The editorial, responsibly, cautions healthcare providers to alert women to the potential consequences of their choices around deferring pregnancy. However, the role of men in these putative “choices” that women are making is scarcely mentioned. Far too many men enter the equation—those who are dragging their feet until they might just about be ready to father a child before removing the (by then often redundant) condom.

Can we try to resist the temptation to single out women when pointing to the problems with delaying pregnancy? Instead, should we not encourage more male partners into the consultation room and pass the message to both parties? We all know, after all, that it takes a healthy egg and quality sperm to make a child.

Bewley et al remind us that doctors and healthcare planners need to grasp the public health threat posed by middle age pregnancies. However, they need to support women and men to achieve biologically optimal childbearing.

Unfortunately, far too many women risked heartbreak by keeping their fingers (and legs) crossed, only to find they were

waiting for nothing. I hope we can finally put this skewed argument to bed.

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¹ Bewley S, Davies M, Braude P. Which career first? *BMJ* 2005;331:588-9. (17 September.)

Women don't want it all, but they may want children

EDITOR—The use of the phrase “epidemic of pregnancy in middle age”¹ is loaded with value judgments and implies that pregnancy in middle age is akin to a disease. An epidemic by definition is a widespread occurrence of an infectious disease in a community at a particular time or a sudden, widespread occurrence of an undesirable phenomenon. In the words of Bewley et al,¹ most pregnancies in women older than 35 have good outcomes. Childbearing late in life carries “risk,” but risk itself is not a disease, and there is little evidence that women in general are unaware of these risks, particularly those who elect to have children later in life.

Bewley et al are right to target social and economic conditions influencing women's reproductive choices but give no evidence to substantiate their sweeping judgment that “women want it all.” The probable truth is that women or couples turn to fertility treatment for a variety of reasons and this is as true for those who want children late in life as it is for those who need fertility treatment early in life.

To brand women as being selfish is absurd and unfounded. Throwing together selective data on risk from disparate sources and without context merely serves as a scare tactic rather than rational discussion. Although older women are more likely to be obese, be taking drug treatment, have a medical disorder, experience severe morbidity, or die, the reference they give for this (confidential inquiry into maternal and child health²) also shows that social disadvantage, poor communities, minority ethnic groups, late booking or poor attendance, domestic violence, substance abuse, suboptimal clinical care, and lack of inter-professional or interagency communication are all contributing factors to poor outcome. For suboptimal clinical care the contribution is higher (67%) than that given for obesity (35%).

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¹ Bewley S, Davies M, Braude P. Which career first? *BMJ* 2005;331:588-9. (17 September.)

² Confidential Enquiry into Maternal and Child Health. *Why mothers die 2000-2002—report on confidential enquiries into maternal deaths in the United Kingdom*. www.cemach.org.uk/publications/WMD2000_2002/content.htm (accessed 19 Sep 2005).

Financial and social reasons should have been taken into account

EDITOR—I wonder about society's motives behind the editorial by Bewley et al and whether there are vested interests.¹ Could it be that the government is worried about a falling birth rate and thinks that older women will fail to have as many children as they would if they were younger? If that's the case there are already far too many people in this country, so it can only be a good thing.

Women who put off having children until later in life—whether by choice or circumstance—tend to be better educated and better informed. We don't need to be “nannied” and told about the risks, etc: we already know—it is well documented and common sense.

If we are leaving having children until later we often do so for financial reasons, but successive governments have created these. Just living from day to day is hard enough, and many young couples can't even afford their own property, let alone a child. Surely it is being responsible to wait to have a child until you are in a stable relationship and have the financial means to support a family, rather than being a single mother or going on benefit, or both?

The authors should have taken financial and social reasons into account too, and then we'd have had a more balanced view.

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¹ Bewley S, Davies M, Braude P. Which career first? *BMJ* 2005;331:588-9. (17 September.)

Economic perspective on later pregnancy is positive

EDITOR—The concept that fertility wanes with increasing age is not new.¹ We do not need research to show that in vitro fertilisation and obstetric complications cost the NHS more than unassisted, uncomplicated pregnancies.

However, to say that a rise in maternal age in itself may be expensive begs the question “for whom?” Women who spend longer in education and then climb a competitive career ladder are likely to have higher lifetime earnings, pay more in tax, make fewer demands on the welfare state, and enjoy better health than those who leave school and start their families earlier.

From society's economic standpoint—the perspective of United Kingdom plc—later pregnancies, which the authors accept may pose little absolute risk to the mother, may be a good thing.

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¹ Bewley S, Davies M, Braude P. Which career first? *BMJ* 2005;331:588-9. (17 September.)